Application for Medical/Osteopathic Licensure
Kentucky Board of Medical Licensure

310 Whittington Parkway
Louisville, Kentucky 40222
(502) 429-7150, Ext. 222 Calls Taken 8:00am – 12:30pm, ET

All applicants for licensure in Kentucky are required to submit their background credentials to the Federation Credentials Verification Service (FCVS). FCVS is a service of the Federation of State Medical Boards and was created to help simplify the licensure process for physicians, both MD's and DO's. FCVS provides a permanent central depository for documents, which represent the core credentials of any physician. FCVS will conduct a primary source verification of those documents at the time they are submitted, and the physician will not be required to re-verify that information when applying to other state medical boards. (Most states accept FCVS, but you may want to check with each state that you wish to apply for medical licensure) **The FCVS application AND the Kentucky Board of Medical Licensure application are to be completed simultaneously but independently**. Notification of any materials needed by either organization to complete the application, will be forwarded separately to you by the FCVS or the Kentucky Board of Medical Licensure

FCVS Application Process

The primary source credentials of core documentation are verified in one uniform process created by FCVS and used in a lifetime portfolio for the applicant. **By using this service, the following core credentials are verified and kept in your lifetime portfolio for future credentialing by the FCVS:**

Identity
Medical Education Verification
Postgraduate Training Verification
Exam Scores
ECFMG and/or Fifth Pathway

You should **first** complete the FCVS application form and forward that directly to the FCVS along with their required fees. You should expect the FCVS verification process to take a minimum of eight weeks if this is your initial application with the FCVS. The address, telephone number and website are:

Federation Credentials Verification Service
PO Box 970900
Dallas, TX 75397-0900
(888) 275-3287
www.fsmb.org

The FCVS will provide all support of their credentialing process. Do Not contact the Kentucky Board of Medical Licensure regarding the FCVS application. The FCVS has a dedicated staff to ensure the processing of your application in professional and timely manner. The FCVS will provide an acknowledgment of receipt of your application in approximately **three days**, a subsequent notice of items needed to complete the credentials verification process in approximately **ten days**, and periodic reminders about any materials that remain outstanding every **three weeks** thereafter. In addition, each applicant will be given a unique PIN number that will allow you to check the status of your application on-line. If you have previously completed the application process through FCVS, you will need to request a subsequent application packet. This process should take approximately 3-4 weeks and be virtually pain-free!

Upon completion of all information and a final review for accuracy, the FCVS will forward your "Physician Information Profile" containing certified photocopies of your credentials directly to the Kentucky Board of Medical Licensure.

Kentucky Board of Medical Licensure Application Process

Next, you will need to complete the application for the Kentucky Board of Medical Licensure (KBML) and submit this application directly to the Board along with the $250.00 fee. You may submit your KBML application to the Board at the same time that you submit your FCVS application to the Federation of State Medical Boards. KBML will use this information, along with the FCVS Profile, to assess your qualifications for licensure.

Applications will be reviewed in the order they are received in our office. It takes approximately 60 – 90 days to complete the processing of an application, assuming you have submitted all necessary forms and all outside information/verifications have come in to the Board, including the FCVS Profile. If you have malpractice, disciplinary history, or we receive any negative or derogatory information during the processing of your application, ***you will need to allow an additional 30 – 60 days to complete***. **The Board does not accelerate processing of one applicant at the expense of another because of a premature commitment made on your behalf, nor will it forego any elements of its screening process. Please do not make firm commitments to start work on any certain date until you have your license in hand.**

Once your application has been reviewed, you will receive an acknowledgement letter advising you of anything still needed to complete your file. You should allow at least 30 days for this process. Please do not contact the Board for the status of your application until such time. ***Only the applicant and the person authorized by the applicant will be able to obtain information regarding your file***.

Applications must be printed legibly or they will be returned. Please complete all questions in its entirety. Do not leave any blanks or time not accounted for. Mark N/A in areas not applicable. Incomplete applications will remain in our office for one (1) year from the date your application is stamped received in our office. After one year, your file will be purged and you will have to start the application process over in its entirety including the fee. Also note that the **$250.00 licensure fee is non-refundable** so be sure that you meet **all requirements** for licensure, which are listed on the following page before completing and returning the application to this office.

We ask your cooperation in limiting your calls to the office to check on the status of your application. Please allow at least 30 days to receive notification of receipt and status (this could be delayed during peak months). When we use our limited staff resources on the phone, we are forced to delay processing of applications. All information regarding the status of a file will be in writing or may be obtained by calling (502) 429-7150 Ext. 222 between 8:00 a.m. and 12:30 p.m., ET, Monday through Friday. ***Please note that calls will only be taken during this timeframe.***

Requirements for Medical/Osteopathic Licensure in Kentucky by Endorsement

1. All applicants' must be a graduate from a medical school approved by the Board. All medical schools located in the United States and Canada approved by the Liaison Committee on Medical Education (LCME) or the Canadian Medical Association are approved by the Board. Medical education obtained outside the United States or Canada is evaluated by the Board on an individual basis and must be listed in the World Health Organization directory of medical schools.

2. All applicants must complete a minimum of **two (2) years post-graduate residency training** approved by the Accreditation Council for Graduate Medical Education (ACGME), the American Osteopathic Association (AOA). Canadian training programs accredited by the National Joint Committee for Approval of Pre-Registration Physicians Training Program, the Royal College of Physicians and Surgeons of Canada or the College of Family Physicians are considered equivalent to graduate medical education in an approved training program in the U.S.

3. All applicants must have passed an approved licensing examination in which all parts, components and/or steps have been completed within a **seven (7) year time frame** from the passing of the first Step, Part or Component. The following examinations are acceptable:
    - **USMLE** Steps 1, 2, 3
    - **NBME** Parts 1, 2, 3
    - **NBOME** Parts 1, 2, 3
    - **FLEX Component 1 and Component 2**(75 or above on each component)
    - **FLEX** taken in one sitting with a FLEX weighted average of 75 or above
    - **State Board Exam** if taken prior to 1972 with overall average of 75 or above in one sitting
    - **COMLEX**
    - **LMCC**

4. International medical graduates ***must*** possess permanent ECFMG certification or proof of being a diplomat of an approved American specialty board.

5. All applicants must be able to understandably speak, read, and write the English language.

If you meet these requirements, please complete the enclosed Application packet for Medical Licensure. **If you do not meet all of these requirements, YOU SHOULD NOT CONTINUE** with this application packet, as the **fee is nonrefundable**.

Applicant's Checklist

The following is a summary of items to help you complete your application process. Please refer to the application for complete instructions. **This form is your checklist to keep.**

_____ **FCVS Application submitted directly to FCVS with Fee**

_____ **Form 1 – License Verifications (Send to every Board where licenses have been held)**

_____ **Form 2 – Hospital/Clinic Affiliation Listing(Send directly to KBML)**

_____ **Form 2A – Hospital/Clinic Affiliation Verification(Send to each facility you have practiced medicine in the last 5 years)**

_____ **Form 3 – Reference Form (2 Required) – Mailed to _____ and _____**

_____ **Form 4 – Release and Waiver of Rights**

_____ **Form 5 - National Practitioner Data Bank "Self Query" Report(On-line: www.npdb-hipdb.com) - Be sure to forward to KBML everything that is sent back to you from NPDB once the reports have been requested. Two reports are sent directly from NPDB, be sure to forward all.**

_____ **Recent Photograph – 2x2 passport attached to application where indicated**

_____ **Form 6 - AMA Profile/AOA Profile (www.ama-assn.org/amaprofiles)(www.aoa-net.org) - This should be completed on-line and AMA/AOA will send directly to KBML.**

_____ **Form 7 - HIV/AIDS Education Requirement(Copy of certificate once completed for full license) http://chfs.ky.gov/dph/training**

_____ **Form 8 - CME Form**

_____ **Form 9 - Criminal Background Check**

_____ **Temporary Permit Request Form (If needed)**

_____ **Application with $250.00 Non-Refundable Fee Mailed to KBML on _____**

Application Instructions
Faxes Will Not Be Accepted

Required fees include:

> **$250.00** Initial Licensure Fee made payable to: ***Kentucky Board of Medical Licensure***
> **(This fee is non-refundable and must be submitted with your application)**

Please print clearly. All questions must be answered. Incomplete or illegible applications will be returned. Scanned applications are not accepted.

Item 1 - Important - Use your full legal name, in the format indicated. Do not use nicknames, etc. This is the name that will be printed on the license and reported to hospitals and those who inquire about licensure. List the degree designation as conferred by your medical/osteopathic school.

Items 2 - 3 - Provide your mailing address of where you will be **practicing** in Kentucky. (This address will appear on our web site) Also provide your current mailing address if different. (**All correspondence will be mailed to Address 2**). It is your responsibility to keep the Board advised of any address changes.

Items 4 – 11 – Answer all questions completely and truthfully.

Item 12 – Please check one box. If more than one is checked we will take the first one indicated.

Item 13 – International Graduates only. List your complete ECFMG #.

Item 14 - List ***all*** colleges and medical/osteopathic schools attended in chronological order.

Item 15 - List the state or Canadian Province in which you received your first full and unrestricted license to practice medicine. (This will be your *endorsed by* state)

Item 16 – List all licenses you currently hold **and/or have ever held** (Include training licenses).

Item 17 – List all training you have received in the United States and/or Canada. All applicants must complete a minimum of two (2) years accredited post-graduate training in the United States or Canada to meet eligibility requirements.

Item 18 - List in ***chronological order*** all locations where you have practiced medicine/osteopathy since obtaining your original license. Account for dates. ***BE ACCURATE AND COMPLETE, INCLUDE VACATION PERIODS.***

Item 19 – List all parts of the licensing examinations you have taken.

Category I and II - If you answer **YES** to any of these questions, submit a **typewritten detailed** explanation of the events.

Verification of Primary Source documents
(Faxes Will Not Be Accepted)

Form 1 - Verification of Licensure - This form must be completed by each state/province in which you ***currently hold or have ever held*** any license to practice medicine/osteopathy (Include temporary and/or training licenses). This form must be sent ***directly*** to us from each state board and must contain the seal of the state board. Any fees required for the completion of this form are your responsibility.

Form 2 - Hospital/Clinic Affiliations - Complete this form and return along with your application to the Board. List all hospital/clinic affiliations held for the past five (5) years. **List all places you have practiced medicine in the past 5 years.** ***Include all locum tenens assignments and moonlighting.***

Form 2A - Hospital/Clinic Affiliation Form - This form must be completed by all hospitals and/or clinics, locum tenens assignments, and/or moonlighting within the past 5 years. Include all places you have practiced medicine in the past 5 years. This form should be completed by administration or chairpersons. **(*Do not include your own private practice)***

Form 3 - Reference Forms - These forms must be completed by two physicians who are familiar with your medical practice. If you are a resident applying for your first license, these forms should be completed by the Program Director and a Senior attending physician who is familiar with your medical practice.

Form 4 - Release and Waiver of Rights Form - Please read carefully. This form should be signed in front of a notary and returned along with your application.

Form 5 - National Practitioner Data Bank Request - This must be completed on their web site at: www.npdb-hipdb.com **When you receive the Self-Query Report, forward *both* originals to the Kentucky Board. One report will be completed by npdb and one report by hipdb.**

Form 6 - AMA/AOA Physician Profile Request – American Medical Association-please contact directly at (312) 464-5000 or visit their web site at: www.ama.assn/org/AMAPhysicianProfiles American Osteopathic Association-please contact directly at (312) 280-5800 or visit their web site directly at: www.aoa-net.org/ProductsServices/services.htm

Photograph – Attach **(do not staple)** a recent 2x2 **passport** photograph where indicated. Sign and date across the bottom. Photo must be no more than six months old and must be an original photograph. (Copies and scanned photos not accepted)

Form 7 - HIV/AIDS Education - Effective July 1, 1991, all applicants for medical licensure must comply with the two (2) hour HIV/AIDS education requirement mandated by the Kentucky General Assembly. ***The enclosed Affidavit of Reasonable Cause may be signed. However, the completed course certificate must be submitted before a full and unrestricted license will be issued.*** A list of courses may be obtained from their web site at: **http://chfs.ky.gov/dph/training**

Form 8 - CME Form – List all Category I CME credits you have obtained within the past **three (3)** years**.** ***DO NOT SEND DOCUMENTATION.***

Form 9 – FBI Criminal Background Fingerprint Card - As of 8/15/2003, all persons applying for a Kentucky Medical License must submit an FBI Criminal Background Check according to KRS 311.565. Details are enclosed as to how to obtain this information and submit it to the Board. ***No applicant shall be issued a medical license until this background check has been received and cleared.***

Kentucky Board of Medical Licensure

310 Whittington Parkway, Suite 1B
Louisville, KY 40222
(502) 429-7150

Application for License to Practice Medicine/Osteopathy by Endorsement

NOTE: Application must be legible and fully completed with all requested information and documentation supplied. Initial licensure fee of $250.00 must accompany application. This fee is non-refundable. *06/30/05*

SSN: ____-___-_____

1. Name in Full:

_____

(first) (middle) (last) (degree)

2. Address1:Practice address in Kentucky: (A license will not be issued without this)
   Street: _____

   City, State: _____Zipcode: _____

3. Address 2: Mailing address (**All correspondence regarding application will be sent to this address**):
   Street: _____

   City, State: _____Zipcode: _____

4. DEA #(if applicable): _____

5.Work#: ( )_____

6.Home#: ( )_____

7. Date of Birth: _____

8.Birthplace_____

9. Have you ever applied for or been issued a Kentucky medical license? ☐Yes ☐ No If Yes, #_____

10. Specify reason for requiring medical licensure in Kentucky: _____

11. Specialty: _____ American Specialty Board Certification: _____

12. Specify your type of practice: (check one)

☐Hospital Base	☐Occupational Medicine	☐Instructor	☐Military
☐Admin. Medicine	☐Research	☐Resident/Fellow	☐Emergency Medicine
☐Private Practice	☐Inactive/Semi-Retired	☐Locum Tenens	

13. Indicate your ECFMG number:(International Medical Graduates only) _____

14. List the name, location and dates of attendance of every college and medical/osteopathic school you have attended:

Name	Location	Dates (From-To)	Degree

15. In what state or Canadian province did you receive your **original license** to practice medicine/osteopathy?

State/Province	License #	Date of Issuance	Current? Yes/No

16. List all other states and Canadian provinces where you **currently hold or ever held** any type of medical/osteopathic license:

State/Province	Type	License #	Date of Issuance	Current? Yes/No

17. List all internship, residency and fellowship programs you have completed since medical/osteopathic school graduation:*(Please list in chronological order)*

INTERNSHIP: (List US and Canadian only)

Hospital: _____City, State: _____

Specialty: _____ To – From: _____

RESIDENCY: (List US and Canadian only)

Hospital: _____City, State: _____

Specialty: _____ To – From: _____

RESIDENCY: (List US and Canadian only)

Hospital: _____City, State: _____

Specialty: _____ To – From: _____

18. *In chronological order*, list all locations where you have practiced medicine/osteopathy since obtaining your original licensure. Also list and explain dates of all extended absence periods. **Please attach additional sheets if necessary**.

Location, City, State	Type of Activity	Dates (From-To)

19. Indicate which licensing examination(s) you have taken. Include all attempts, locations, scores, and dates. Be exact, including all attempts and failures.

Type (FLEX,NBME,USMLE,LMCC,etc)	Location	Score	Date

[Category I]

Please answer all questions on this application. Category I will help the Board determine if you meet the essential eligibility requirements for licensure by virtue of your background, education, training and experience. If you are qualified to practice under Category I, Category II will be reviewed to help the Board determine if you are qualified to practice safely and competently, with or without reasonable modification. If you answer "Yes" to any of the questions, you must attach a complete written explanation of the event(s) or condition(s), including dates, names, addresses, circumstances, and results along with your returned application.

NOTE: Intentional false answers or misrepresentation in applying for or procuring a license, registration or reactivation in Kentucky are grounds for disciplinary action, including denial or revocation of license, and are reported to the National Practitioner Data Bank and/or appropriate national professional credentialing organization. You must answer "yes" to any question if the event(s) described in that question has actually occurred. You must answer "yes" in such circumstance even if you have been advised by an attorney or other person that you may answer "no". You must also answer "yes" in such circumstance even if the record of the event has been sealed or expunged by Court order, or has been designated "confidential" by the body involved. After answering "yes" to the appropriate question(s), you may advise the Board of any additional relevant information pertaining to your answer (i.e., record has been sealed or expunged, record is designated "confidential," attorney has advised that you properly answer "no"). The Board will consider this additional information, along with your answer(s), in determining the appropriate action. If you have any question about whether or not you should answer "yes" to a question, you should err in favor of answering "yes" and providing an explanation, because any non-disclosure violation will likely result in denial of your application or disciplinary action against your license. This application may not be altered in any way.

1. Have you ever been dismissed from, resigned while under investigation, failed to complete an academic year, taken a leave of absence, or been placed on probation or reprimanded at a medical school or a postgraduate training program?
   ☐Yes ☐No
2. Are you currently in default on any student loan repayment obligations payable to the financial aid programs administered by the Kentucky Higher Education Assistance Authority?
   ☐Yes ☐No
3. Have you ever been denied a license or denied the privilege of taking a licensure examination by any State, Federal or International licensure jurisdiction?
   ☐Yes ☐No
4. Have you ever had any license, certificate, registration or other privilege as a health care professional denied, revoked, suspended, probated, restricted or limited, or subjected to any other disciplinary action, by a State medical/osteopathic licensing board, or Federal, or International authority?
   ☐Yes ☐No
5. Have you ever been disciplined by any licensed hospital (including postgraduate training) or the medical staff of any licensed hospital, including removal, suspension, probation, limitation of hospital privileges or any other disciplinary action if the action was based upon what the hospital or medical staff found to be unprofessional conduct, professional incompetence, malpractice or a violation of a provision(s) of a Medical Practice Act?
   ☐Yes ☐No
6. Have you surrendered such credential, or placed it into an inactive status, to avoid disciplinary action or in connection with or in anticipation of a disciplinary investigation/action by the licensing authority of such jurisdiction?
   ☐Yes ☐No
7. Have you ever resigned your privileges or failed to renew privileges at a licensed hospital or from the medical staff of the hospital, while under investigation or while you were subject to disciplinary proceedings by the hospital?
   ☐Yes ☐No
8. Have you ever been removed, suspended, expelled or disciplined by any professional medical facility, association or society?
   ☐Yes ☐No
9. Have you ever voluntarily or involuntarily surrendered a medical or osteopathic license, or controlled substance registration certificate issued to you?
   ☐Yes ☐No

10. Have you ever been or are you currently under investigation by any State, Federal or International licensure authority or any drug licensure/enforcement authority?
    ☐Yes ☐No
11. Are any legal proceedings regarding licensure presently pending against you by any State, Federal or International licensure authority or any drug licensure/enforcement authority?
    ☐Yes ☐No
12. Have you ever been convicted of a felony or misdemeanor by any State, Federal or International court?
    ☐Yes ☐No
13. Are any criminal charges presently pending against you in any of those courts?
    ☐Yes ☐No
14. To your knowledge, are you the subject of an investigation for a criminal act?
    ☐Yes ☐No
15. In the past ten (10) years have you had to pay a judgment in a malpractice action or other civil action against your medical practice or are any malpractice or other civil actions against your medical practice presently pending in any court? **(If yes, complete enclosed Medical Malpractice Form)**
    ☐Yes ☐No

I hereby state that the information contained in this application has not been altered in any way and is true, accurate, and complete to the best of my knowledge and belief. I understand that under Kentucky law the submission of any false, fraudulent or forged statement, document or other matter in connection with this application is grounds for criminal prosecution and the denial of licensure. I authorize the Board (KBML) or its agents to obtain from other sources any information necessary for determining my qualifications for licensure. I also authorize them to furnish any information they may now or in the future have concerning my qualifications and fitness to practice medicine/osteopathy to any person, institution, association, school, hospital or government entity.

_____

(Signature of Applicant) **(Date)**

_____

(Print Name)

Subscribed and sworn to before me by the above named applicant on this ___day of _____
(month,year)

_____

(Signature of Notary)

My commission expires: _____

Seal of Notary

Attach current 2x2 passport photograph here. Sign and date across bottom. Photo must be a head and shoulder view and must be taken within six months of application.

"Only the applicant and person authorized by applicant may call regarding the credentialing of your application or be given information during the credentialing process."
Specify name of authorized person:_____

[Category II]

The answers to these questions are exempt from public disclosure under KRS 61.878(1)(a) and (I) and KRS 311.619 and shall be subject to inspection only upon order of a court of competent jurisdiction, except that no court shall authorize the inspection by any party of any materials pertaining to civil litigation beyond that which is provided by the Kentucky Rules of Civil Procedure governing pretrial discovery. The answers to these questions may be considered by the Board (KBML) and may be disclosed in any contested case proceeding, including a Show Cause proceeding, or appeal of a licensing decision based upon them.

"Illegal drug use" means the use of an illegally obtained controlled substance or dangerous drug; the term "illegal drug use" also means the use of a legally obtained controlled substance or dangerous drug which is not taken in accordance with the direction of the licensed health care professional who prescribed the controlled substance or dangerous drug.

1. Do you currently, or have you had within the past 5 years, any physical, mental, or emotional condition which impaired, or might reasonably impair your ability to practice your health care profession safely and competently?
   ☐Yes ☐No
2. Within the past 5 years, have you been admitted to any hospital or other in-patient care facility for any physical, mental or emotional condition, which impaired, or might reasonably be considered to impair, your ability to practice your health care profession safely and competently?
   ☐Yes ☐No
3. Do you currently have, or have you had within the past 5 years, a dependency on or abuse of the use of alcohol or drugs, which impaired, or might reasonably impair, your ability to practice your health care profession safely and competently?
   ☐Yes ☐No
4. Within the past 5 years, have you engaged in the excessive use of alcohol or illegal drugs, or received any in-patient or outpatient or individual therapy/treatment or been hospitalized for alcoholism, or illegal use, or been arrested for a DUI (Driving Under The Influence)?
   ☐Yes ☐No
5. Within the past 5 years, have you been the subject of any chemical substance screening test which resulted in an indication of the presence in your body of any controlled substance, any dangerous drug, or alcohol level above .10% BAC? (This does not include those drugs taken by you as a result of a legitimate health care diagnosis, and prescribed for you in good faith by another licensed health care professional.)
   ☐Yes ☐No

I hereby state that the information contained in this application has not been altered in any way and is true, accurate, and complete to the best of my knowledge and belief. I understand that under Kentucky law the submission of any false, fraudulent or forged statement, document or other matter in connection with this application is grounds for criminal prosecution and the denial of licensure. I authorize the Board (KBML) or its agents to obtain from other sources any information necessary for determining my qualifications for licensure. I also authorize them to furnish any information they may now or in the future have concerning my qualifications and fitness to practice medicine/osteopathy to any person, institution, association, school, hospital or government entity.

_____

(Signature of Applicant) **(Date)**

_____

(Print Name)

Subscribed and sworn to before me by the above named applicant on this ____day of _____
(month, year)

_____

Seal of Notary **(Signature of Notary)**

My commission expires:_____

Application Deadlines and Board Meetings

In order for your application to be presented to the Board, your application must be completed in its entirety and must be on file in the Board office by the deadline dates listed below **(There will be no exceptions to the deadlines).** The fact that you have mailed the application form and fee does not constitute a completed application. Your application is complete when the Board staff has reviewed all parts of the application. You should allow four to six weeks for attachments to reach this office and be incorporated into your file.

Deadline Dates	**Board Meeting Dates**
February 11, 2005	March 17, 2005
May 6, 2005	June 16, 2005
August 12, 2005	September 14, 2005
November 11, 2005	December 15, 2005

If your application is not complete by the deadline, you may request a temporary license (***see enclosed Temporary Permit form***). This would allow you to start practicing for a period not to exceed six months and carry you over until the following Board meeting to be approved for a full license provided there is nothing negative or derogatory in your completed application.

Temporary Permit Form

KRS 311.575 provides that Temporary permits may be issued **at the discretion of the Executive Director**, provided the applicant for a full license has a **completed application with all supporting documents** on file with the Board, meets all statutory requirements for licensure, and needs to begin working in Kentucky before the next regularly scheduled meeting of the Board. ***You must request the Temporary Permit by completing this form; it is not automatically issued.***

Temporary Permits will not be issued to an applicant who has a prior history of disciplinary action taken by a licensing jurisdiction or hospital, a criminal record, a history of substance/chemical abuse or any negative or derogatory information. This also includes any malpractice cases in the last ten years in which you paid a settlement of $100,000 or more.

The Temporary Permit will not be issued until all administrative screening processes are complete including the FCVS Profile. Do Not make any commitments prematurely. The Board recommends that you do not make any commitments to accept a position in Kentucky until you have a Temporary Permit *in hand*.

You may request a Temporary Permit by completing this form and returning it directly to the Board:

Name: _____, M.D./D.O.
(please print)

Practice Location in Kentucky: _____

_____

Date Temporary Permit Requested: _____

Address Temporary Permit should be mailed: _____

_____

Please Note: You will not be issued a Temporary Permit to practice in Kentucky without a specific Kentucky practice address listed on this form.

Kentucky Board of Medical Licensure

310 Whittington Parkway Suite 1B
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(502) 429-7150

Complete this form only if you answered "yes" to Category I, Question #15. This form must be completed if you have ever been named as a defendant in a malpractice lawsuit, verdict or settlement. Your application is not complete until this form has been returned to the Board.

_____

Name of Physician *Office Telephone No.*

_____

Address *City* *State* *Zip*

***Malpractice Complaint**: (Include name of patient, age, sex, date of occurrence and location, i.e., office or name and address of hospital.)*

Patient's Name: _____

Age: _____ *Sex:* _____

Date/Place of Occurrence: _____

Indicate you position in case, i.e., resident, primary physician, etc: _____

_____

Filed Against: *( ) Individual Doctor ( ) Group ( ) Hospital*

List names of other defendant-doctors and/or hospitals: _____

_____

Disposition: *( ) Pending ( ) Jury Verdict ( ) Settled*

If there has been a verdict or settlement, please provide the following information:

Legal outcome: _____

Date: _____ *Total Amount Paid (if any):* _____

Amount attributable to you: _____

Send To This Board Copies Of The Complaint, Answer, Release, Settlement Documents, All Other Relevant Legal Documents.

On A Separate Sheet, Please Provide A Detailed Explanation Of Background And Medical Issues Involved In The Case.

Signature: _____ *Date:* _____

→ *A separate report must be completed for each malpractice suit. This form may be duplicated. Please return form(s) and other information to the Board at the above address.*

Form 1

Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222

Verification of Licensure

To Applicant: In applying for a license to practice medicine/osteopathy in the Commonwealth of Kentucky, the Kentucky Board of Medical Licensure requires **each** state or Canadian province where you **currently hold or have ever held** a medical license complete this form. My signature below is your authority to release any and all information in your files, favorable or otherwise regarding myself.

Name of Applicant: _____M.D./D.O. License No:_____
(Please print)

Address:_____

_____M.D./D.O.
(Signature)

****

To Reference Source: Please complete this form, sign, seal and return directly to the Board (KBML) at the above stated address. Any fees for completion of this form should be collected from the physician. All applicants have signed a general release, which relieves anyone of any liability for information furnished in good faith.

• • • Please Type or Print All Information • • •

State of:_____License No:_____

Issue Date:_____ Expiration Date:_____

Basis for Licensure:_____

Current Status:_____

Limitations: _____

Derogatory:_____

_____

Signed: _____

Board Seal

Title: _____

Form 2

Physicians Name _____M.D. / D.O.

List all hospitals, clinics, etc., other than training where you have practiced medicine within the last five (5) years <u>and send Form 2A to each</u>. *(This should also include moonlighting, administrative, and all locum tenens assignments.)*

Dates **(From – To)**	Hospital/Clinic/Office Name	Complete Address	**Indicate Locum Tenens, Moonlighting or Type of Privileges**

Form 2A

Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222

Hospital, Clinic, Facility Affiliation Form

To Applicant: In applying for a license to practice medicine in the Commonwealth of Kentucky, the Kentucky Board of Medical Licensure requires this form to be completed by an administrator or chairperson in each facility where you have practiced medicine during the five (5) years preceding your application. My signature below is your authority to release any and all information in your files, favorable or otherwise regarding myself.

Name:_____M.D./D.O. _____
(Please print) (Signature)

Name and Address of Facility:_____

****

To Reference Source: Please complete this form, sign, and return directly to the Board at the above stated address. The processing time for licensure depends on timely receipt of critical forms such as this. All applicants have signed a general release, which relieves anyone of liability for information furnished in good faith. ***No Substitutions will be accepted in lieu of this form. All other forms submitted will be returned.***

1. Position and Department of the above applicant?_____
2. Affiliation Dates: From _____To _____
3. Were any limitations imposed on this physician?_____ If ***"Yes"***, please explain briefly and attach certified copies of any documentation pertaining to such action._____
   _____
4. Were privileges ever revoked, suspended, restricted, limited, reprimanded, placed on probation or otherwise disciplined?____ If ***"Yes"***, please explain briefly and attach certified copies of any documentation pertaining to such action. _____
   _____
5. Was the above physician terminated from employment? _____ If yes, please explain in detail.

   Derogatory Information, if any:_____

   Comments, if any:_____

Signature, Date, Title _____

Printed Name _____

Facility _____

Affix Seal Here

Address _____

(If no seal, so indicate)

_____

Phone Number _____

Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, KY 40222

Reference Form

To applicant: The Kentucky Board of Medical Licensure requires completion of two (2) Reference Forms from reference sources. These forms must be sent from the reference source ***directly*** to the Board at the above address.

In addition, the forms must meet the following criteria:

(a) Recent (no older than 6 months)
(b) Original signature
(c) Sent by licensed physician familiar with your practice. It is preferable that one be sent by the Program Director for those who recently completed residency training, or the last hospital where staff privileges were held.

Please be sure to indicate your name below for identification purposes.

Name of applicant:_____
(Please print)

****

To reference source: Please complete this form, sign and return directly to the Board at the above stated address. All applicants have signed a general release, which relieves anyone of any liability for information furnished in good faith.

From: _____
(Full Name – Please Print)

_____
(Address) (City, State, Zipcode)

Telephone: (_____) _____

1. How long have you known the applicant? _____

2. In what capacity are you acquainted with him/her? _____

		Yes	No	Not Applicable
3.	Have you ever received reports of poor practice by this physician or have you discussed concerns you had about his/her practice with medical staff officers at a hospital?	☐	☐	☐
4.	Have you ever received reports of poor relationships between this physician and other members of hospital medical staff?	☐	☐	☐
5.	Are you aware of any derogatory information about this physician with respect to his/her ability to practice medicine?	☐	☐	☐

→ Note: If you answer "NO" to questions 10, 11 or 13, please give an explanation.

		Yes	No	Not Applicable
6.	Does he/she have, or has he/she had in the past, any mental or physical illness or personal problems that interfere with his/her medical practice?	☐	☐	☐
7.	Has he/she ever abused alcohol or drugs or shown any signs of chemical dependency?	☐	☐	☐
8.	Are you aware of any lawsuits having to do with his/her medical practice that this physician has either lost or settled out of court?	☐	☐	☐
9.	Are you aware of any restrictions, limitations or other actions of any nature taken against this physician by a hospital or other health related entity?	☐	☐	☐
10.	Does this physician accept medical staff and hospital policies and function willingly according to these policies?	☐	☐	☐
11.	Does he/she enjoy professional respect among his/her colleagues and in the community where he/she practices?	☐	☐	☐
12.	Are you sorry to see this physician leave your community?	☐	☐	☐
13.	Do you recommend him/her for unrestricted medical licensure in Kentucky?	☐	☐	☐

Comments: _____

_____

_____

Signature and Date _____

Title _____

Printed Name _____

Telephone Number _____

Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, KY 40222

Reference Form

To applicant: The Kentucky Board of Medical Licensure requires completion of two (2) Reference Forms from reference sources. These forms must be sent from the reference source to the Board at the above address.

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Please be sure to indicate your name below for identification purposes.

Name of applicant:_____
(Please print)

****

To reference source: Please complete this form, sign and return directly to the Board at the above stated address. All applicants have signed a general release, which relieves anyone of any liability for information furnished in good faith.

From: _____
(Full Name – Please Print)

_____
(Address) (City, State, Zipcode)

Telephone: (_____) _____

1. How long have you known the applicant? _____

2. In what capacity are you acquainted with him/her? _____

		Yes	No	Not Applicable
3.	Have you ever received reports of poor practice by this physician or have you discussed concerns you had about his/her practice with medical staff officers at a hospital?	☐	☐	☐
4.	Have you ever received reports of poor relationships between this physician and other members of hospital medical staff?	☐	☐	☐
5.	Are you aware of any derogatory information about this physician with respect to his/her ability to practice medicine?	☐	☐	☐

→ Note: If you answer "NO" to questions 10, 11 or 13, please give an explanation.

		Yes	No	Not Applicable
6.	Does he/she have, or has he/she had in the past, any mental or physical illness or personal problems that interfere with his/her medical practice?	☐	☐	☐
7.	Has he/she ever abused alcohol or drugs or shown any signs of chemical dependency?	☐	☐	☐
8.	Are you aware of any lawsuits having to do with his/her medical practice that this physician has either lost or settled out of court?	☐	☐	☐
9.	Are you aware of any restrictions, limitations or other actions of any nature taken against this physician by a hospital or other health related entity?	☐	☐	☐
10.	Does this physician accept medical staff and hospital policies and function willingly according to these policies?	☐	☐	☐
11.	Does he/she enjoy professional respect among his/her colleagues and in the community where he/she practices?	☐	☐	☐
12.	Are you sorry to see this physician leave community	☐	☐	☐
13.	Do you recommend him/her for unrestricted medical licensure in Kentucky?	☐	☐	☐

Comments: _____

_____

_____

Signature and Date _____

Title _____

Printed Name _____

Telephone Number _____

Form 4

Release and Waiver of Rights Form

I, _____, hereby authorize the following individuals and entities to release all information (documented, oral or other) about me in their possession to the Kentucky Board of Medical Licensure (KBML) or its agents:

1. All medical/osteopathic schools that I have attended.

2. All hospitals or other health care facilities at which I have ever held staff privileges, whether full or limited, temporary or permanent; and all hospitals or other health care facilities at which I have ever received training.

3. All medical/osteopathic societies, specialty boards, and other medical/osteopathic organizations with which I have been associated.

4. All other state or Canadian licensure boards, federal health agencies, and federal and state drug control agencies.

5. All licensed physicians, nurses or other health care professionals of any state or Canadian province.

6. All attorneys who have participated in civil or criminal actions in which I was named party.

I hereby release the above-named individuals and entities from all liability for the release of information to the Board (KBML) or its agents.

I further authorize the Board (KBML) or any of its duly authorized agents, to make any investigations that they deem necessary to secure information concerning me, which is relevant to the requirements for licensure. I further authorize them to release such information they may now or in the future have, concerning me to (i) any federal, state, county or local governmental entity, (ii) any hospital or other health care facility, or (iii) any other person upon a showing that the release of the information is vital to the health, safety and welfare of the general public.

I hereby make this release and waiver of rights for the purpose of allowing the Board (KBML) to carry out its duties pursuant to my request for a license to practice medicine/osteopathy in the Commonwealth of Kentucky; and further, for the purpose of allowing the Board (KBML) to carry out its duties in regard to my continued licensure.

This release and waiver of rights has no expiration date and shall remain effective during my licensure in the Commonwealth of Kentucky.

_____

(Applicant's Signature) (Date)

_____

(Print Name)

Sworn to and Subscribed Before Me By the Above Named Applicant on this the ___day of _____, 20 ____.

Seal

_____

Notary Public

My Commission expires:_____

Form 5

National Practitioner Data Bank

The National Practitioner Data Bank is a National Data Bank that collects information from all state medical boards and healthcare facilities.

You will need to complete the form for a self-query report on their website:

www.npdb-hipdb.com

This form, once completed on their website, should be mailed directly to the data bank:

National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank
P.O. Box 10832
Chantilly, VA 20153-0832

The National Practitioner Data Bank will process the reports and **mail them directly back to you**. Once you receive the reports, you must **forward the originals** to the Board.

Please note, you will receive two reports. Be sure to mail all documents received to the Board.

Form 6

AMA/AOA Physician Profiles

AMA Profile – ***To be completed by all allopathic medical school graduates. Including International medical graduates.***

A ***Physician Profile Request*** must be ordered directly from the AMA website. Members and non-members of the American Medical Association must complete this form. You must complete the profile on-line and the AMA will forward your profile request directly to the **Board**:

www.ama.assn/org/AMAPhysicianProfiles

For questions or any problems with their website, please contact the AMA directly (312) 464-5000.

AOA Profile – ***To be completed by all osteopathic medical school graduates only***

A Physican Profile Request must be ordered directly from the AOA website. Members and non-members of the American Osteopathic Association must complete this form. You must complete the profile on-line and the AOA will forward your profile request directly to the **Board**:

www.aoa-net.org/ProductsServices/services.htm

For questions or any problems with this website, please contact the AOA directly (312) 280-5800.

Form 7

Kentucky HIV/AIDS Education
Affidavit of Reasonable Cause

I, _____, request that the Board (KBML) defer my
(Name)

HIV/AIDS education requirement for initial professional licensure (KRS 214.615) for the following reason,

Please explain in detail: _____

_____

_____

I understand that the deferment is valid for six (6) months from the date of the issuance of my temporary permit to practice medicine and is **not renewable.** I further understand that within this six months I must send to the Board (KBML), a copy of a certificate showing completion of a Kentucky Cabinet for Health Services approved HIV/AIDS course for a full and unrestricted license to be issued.

Signature: _____ Date: _____

Printed Name: _____

Social Security Number: _____

→ This form must be sent to the Board (KBML) in order for you to receive a six-month extension. Please retain a copy of this affidavit for your records. Either this affidavit or the completed course must be in the Boards office in order to meet the Board Deadlines. **A list of approved courses may be obtained from the following website: http://chfs.ky.gov/dph/training or by calling (502) 564-4990.**

Mail this form to the following address:

Medical Licensure Coordinator
Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, KY 40222
(502) 429-7150

Kentucky Board of Medical Licensure
HIV/AIDS Education Certificate Requirements

During the 1990 regular legislative session, the General Assembly passed House Bill 425, which mandated Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) education requirements for health professionals. Further, the General Assembly mandated that the Cabinet for Health Services (CHS) administers this program and that the Kentucky Board of Medical Licensure monitor compliance.

On or after September 24, 1991, all applicants for medical licensure must comply with the two (2) hour AIDS education requirement.

Prior to receiving a Kentucky medical license, each applicant for licensure must submit to the Kentucky Board of Medical Licensure one of the following:

- A copy of a certificate of completion of an approved course. The AIDS course (2 hours minimum) must be included on the official listing of approved courses maintained by the Cabinet for Health Services, and the CHS approval number must appear on the certificate. **Certificates without a CHS approval number will not be accepted.**

- An "Affidavit of Reasonable Cause" form if the requirement is not met prior to temporary licensure. If the AIDS course is not completed by the time a temporary license is to be issued, the applicant must complete an "Affidavit of Reasonable Cause" form to verify that the requirement will be met within the next six (6) months. This affidavit shall be valid for no more than six (6) months and is not renewable. Eligible applicants will be issued a Temporary Permit only for this six (6) month period. The full license to practice medicine in Kentucky will not be issued until this requirement is met.

- If an applicant has graduated from a medical/osteopathic school, whose AIDS education is approved by CHS, within five (5) years and has been in a residency program throughout the interim, the applicant shall be deemed to have met this requirement. **Contact the AIDS Education Program at CHS to see if your medical school curriculum has been approved**. (See below)

If you have any questions regarding applicable courses, approval of courses, or if you need to obtain a listing of approved courses, please contact:

http://chfs.ky.gov/dph/training

AIDS Education Program
Cabinet for Health Services
275 East Main Street
Frankfort, KY 40621
(502) 564-4990

Form 8

CME Form

Name_____
(Please Print or Type)

Record of Category I Continuing Medical Education Credits(Last 3 years)

DO NOT PROVIDE DOCUMENTATION

Dates:	**Name of Activity/Course**	**# of Credit Hours**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I attest that the above is valid.

_____ _____

Signature **Date**

Form 9

Kentucky Board of Medical Licensure
Criminal Background Requirements

KRS 311.565

This notice should be provided to all applicants applying for a full-unrestricted Medical/Osteopathic License in the Commonwealth of Kentucky by endorsement.

All persons applying for a Kentucky Medical License on and after August 15, 2003 shall submit proof of a FBI Criminal Background Check to the Board as a part of the application for a license to practice medicine in the Commonwealth. This record must indicate that there have been no felony convictions or pending charges at any time or any misdemeanor convictions or pending charges within the previous five-year period. Some examples of misdemeanors which will be subject to a Board investigation include: DUI, sexual assault, certain theft charges, and drug convictions. In general, speeding and minor traffic violations would not be misdemeanors. Some serious traffic violations could be misdemeanors.

Where can I obtain the necessary FBI forms? To obtain the fingerprint cards, check with your local law enforcement agency (any state), the Kentucky State Police (check www.kentuckystatepolice.org/post.htm for the nearest location), or call the Federal Bureau of Investigation, Criminal Justice Information Services Division at 304-625-3878. You must listen to the Entire recording and request the cards to be sent to you at the very end. You will receive two fingerprint cards in the mail within 3 – 5 days.

Who will take my fingerprints? Most local law enforcement agencies, county sheriff's departments, and some city and county police departments, or any state police post may be able to take your fingerprints. The law enforcement agencies will be taking your fingerprints for a **Personal Review**. Some law enforcement agencies may charge a fee for fingerprinting services. The cost may vary.

What is the cost and where do I send it? Send the completed fingerprint card, a short letter (A sample letter is attached for your review) advising the FBI that the report is desired for personal review, and a certified check or money order, payable to the Treasury of the United States, in the amount of $18 to the address listed below. **If all items are not included, the request will be returned to you by the FBI for correction.**

Federal Bureau of Investigation
Criminal Justice Information Services Section
Attn: Records Request
1000 Custer Hollow Road
Clarksburg, WV 26306

What if my report comes back indicating that the prints are unreadable or indiscernible? If a criminal background report comes back from the FBI indicating that the prints are indiscernible or unreadable, the applicant should have the second set of prints done at the nearest State Police Post and resubmitted to the FBI for processing. If the second report comes back with the same result, then the Board has an affidavit that the applicant can sign before a notary to use for the issuance of a license. All of the **original fingerprint cards and reports** must be submitted along with the affidavit in order for the affidavit to be valid. If the applicant goes to the State Police Post first and that report comes back unacceptable, then he/she must have the prints done at one other location. Thus, no license will be issued to the applicant (using an affidavit) unless there have been at least two FBI reports obtained that indicate a failure to read the prints, one of which resulted in the fingerprints being done by the State Police Post.

Also, we cannot accept a copy of a report that has been done for any other entity or organization. Applicants must have their prints taken and forwarded to the FBI for processing. The original fingerprint card(s) and report(s) must be submitted to our office for processing your application for a medical license.

How long does this process take and how long is the report valid? Approximately **4-6 weeks**, upon submission of the fingerprint card to the FBI. Thus, you should apply for the criminal background report at the time that you submit your application for licensure to the Board. **The report is only valid for one year.**

What should I do if my report is clear? The report will be mailed directly to you. The **original** report(s) and fingerprint card(s) must be submitted for completion of your application for a medical license. Photocopies of the fingerprint card and/or the written report from the FBI are not acceptable.

What happens if I have a conviction or pending charges? You must submit the criminal background report to the Board within five days of receipt of the FBI identification record. The Board will then begin an investigation into the conviction or charges. Just a reminder, you will be asked about any presently pending and/or prior convictions of felonies or misdemeanors on the Board's application for licensure, please be sure to answer these questions in a truthful manner.

If a conviction is noted, how long will the Board's investigation process take? Approximately 60-90 days depending upon how quickly all the documents are returned to the Board and the backlog of cases.

IMPORTANT NOTE: The Board **will not** issue a Medical License to you until we have received the final fingerprint card(s) and background report(s). You may contact the FBI directly at (304) 625-5567 or (304) 625-3878.

If you have further questions, please contact the Board's office between 8:00 a.m. and 12:30 p.m., ET, at (502) 429-7150, Ext. 222.

Kentucky Board of Medical Licensure
Hurstbourne Office Park
310 Whittington Parkway, Suite 1B
Louisville, KY 40222

Federal Bureau of Investigation
Criminal Justice Information Services Division
1000 Custer Hollow Road
Clarksburg, WV 26306

RE: CRIMINAL BACKGROUND CHECK

I am requesting this background check and report for a personal review. Enclosed is the required, completed fingerprint card, along with the $18 processing fee. (Certified check or money order, payable to: Treasury of the United States).

PLEASE RETURN THE REPORT TO ME AT THE FOLLOWING ADDRESS:

Printed or Typed: _____
Full Legal Name

_____
Street Address

_____
City, State, Zip Code

_____
Signature

_____
Date